Assessment strategy 3: Building the capacity of State and local health departments and other relevant organizations to use health information systems to prevent disease, promote health, and increase access to services in their communities

National Institutes of Health (NIH)

1. Initiate demonstration research programs within communities, with the long range intention of enabling them to run their own programs successfully.

1990–91 **1992 and beyond**

• Support training grants and contracts that assist in developing health personnel, including training for epidemiologists, biostatisticians, and behavioral scientists. Fellowship and graduate training programs are targeted for minority scientists.

• Inform the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACHO), and the United States Conference of Local Health Officers (USCLHO) of all scientific meetings conducted and sponsored, and encourage participation by State health officials.

2. Establish a mechanism to share the results of surveys and studies of human populations with ASTHO, NACHO, and USCLHO, as for example, the results of studies to determine the hazards of environmental agents.

1992 and beyond

Indian Health Service (IHS)

1. Develop consultation and technical assistance services to support unique locally determined data needs (*Indian Health Service*).

1992 and beyond

2. Develop a plan for improvement in building assessment capacity in tribal communities and urban organizations.

1992 and beyond

3. Establish a technical support center to disseminate technical programmatic, managerial, and fiscal information to tribes and urban organizations.

1992 and beyond

4. Assess the needs for people and computer hardware and software to develop an IHS maternal and child health surveillance and tracking system in each IHS area that is required to monitor mortality (perinatal, neonatal, postneonatal, and maternal), high-risk pregnancies (teenagers, singles, alcohol and other substance abusers, and those older than 35 years), children with special needs (handicaps, fetal alcohol syndrome, and chronic disease), and instances of suspected or known child abuse.

1992 and beyond

5. Provide research and epidemiology training for IHS area planning and statistical staff members.

1992 and beyond

6. Develop a formal process for including tribes and urban organizations in policy development.

1992 and beyond

7. Develop a comprehensive statement of objectives for raising the health status of American Indians and Alaska Natives, in partnership with tribes and urban organizations, using as a model the Healthy People 2000 Objectives.

1992 and beyond

8. Develop a strategy, in partnership with tribes and urban organizations, for informing critical decision makers of the health status, health resources, and health needs of American Indians and Alaska Natives.

1992 and beyond

9. Intensify recruiting of Indian dentists through onsite recruiting at dental schools, summer placement of scholarship recipients, placement through

the Commissioned Officer Student Training and Extern Program (COSTEP), and preceptor agreements with individual dental schools.
1990–91

10. Complete initial staffing of IHS-level technical support for direct care facilities and three development centers.
1990–91

11. Maintain the program of surveillance of the incidence of severe injury.
1990–91 **1992 and beyond**

12. Implement a formal plan for building assessment capacity.
1990–91

13. Analyze information needs of tribal governments in the area of managerial and fiscal competencies.
1990–91

14. Analyze available self-assessment tools in management and initiate providing them through the technical support center.
1990–91

15. Evaluate available technical and programmatic information for usefulness to tribal governments and urban organizations.
1990–91

16. Analyze the role of State and local governments in providing public health services to American Indians and Alaska Natives, and identify critical decision makers.
1990–91 **1992 and beyond**

17. Provide research and epidemiology training for tribal health planners.
1990–91

18. Identify staffing resources to ensure that each IHS area is capable of maintaining, managing, and analyzing information generated from surveillance and tracking of maternal and child health data, and of disseminating the information to professional and tribal leaders.
1990–91

19. Assess the needs with regard to fetal alcohol syndrome and for FAS special needs coordinators for each IHS area.
1990–91

20. Expand headquarter field support functions to provide an IHS-wide dental disease prevention coordinator, who will assist IHS and tribal dental programs to define, implement, and evaluate dental health promotion and disease prevention activities.
1992 and beyond

21. Provide training and technical assistance to tribal health organizations in the preparation of comprehensive severe injury profiles.
1992 and beyond

22. Train each tribal health organization in the use of the injury surveillance system.
1992 and beyond

23. Develop a plan to increase opportunities for collaborative oral health studies among IHS, tribal organizations, academic institutions, other Federal agencies, and other organizations interested in the oral health of American Indians and Alaska Natives.
1992 and beyond

24. Develop, in partnership with Indian tribes, model standards for dental health promotion and disease prevention programs for IHS and tribal dental programs that will be consistent with programs that have been shown to be effective in other dental public health settings.
1992 and beyond

25. Assess the needs for staff members, such as midwives, public health nurses, and indigenous health workers, necessary to meet the primary direct and preventive maternal and child health care needs.
1992 and beyond

26. Identify and prioritize those unique oral health problems of American Indians and Alaska Natives who require specialty care. Provide training for Indian specialists to meet the ongoing treatment requirements of this population.
1992 and beyond

27. Raise the awareness of IHS and tribal dental health care workers about the role they can play in tobacco cessation programs.
1992 and beyond

28. Establish central data base management capabilities in at least half the IHS areas.

1992 and beyond

29. Develop, test, and implement a culturally relevant program to raise the awareness of American Indian and Alaska Native communities to the causes and risk factors of dental diseases, and methods to prevent them.

1992 and beyond

30. Provide tribal health organizations with the necessary resources, such as staff and equipment, to maintain surveillance of health status, activities, and needs.

1992 and beyond

31. Increase the proportion of the American Indian and Alaska Native population that seeks dental care to a level comparable with that of the overall population.

1992 and beyond

32. Increase awareness in American Indian and Alaska Native communities to a level comparable with that of the overall population of the causes of, risk factors for, and methods to prevent dental diseases.

1992 and beyond

33. Prepare community-specific resource directories, in collaboration with tribes and other organizations.

1992 and beyond

34. Increase awareness among American Indian and Alaska Native communities of the importance of community water fluoridation. Increase the proportion of their residents receiving the benefits of optimally fluoridated water to a level comparable to that of the overall population.

1992 and beyond

35. Decrease the disparity, in partnership with the tribes, in oral health status between American Indians and Alaska Natives and the overall population.

1992 and beyond

36. Train tribal health organizations in developing resource directories.

1992 and beyond

Health Resources and Services Administration (HRSA)

1. Based on the requirements of the 1989 Omnibus Budget Reconciliation Act, HRSA will use the new Maternal and Child Health Block Grant requirements to report infant mortality and related indices to build State and local capacity to promote maternal and child health.

1990–91 **1992 and beyond**

2. Begin a series of meetings with representatives of State and local health agencies, such as the Association of State and Territorial Health Officials, the National Association of County Health Officials, and the United States Conference of Local Health Officers, to discuss their priorities, as well as HRSA efforts to strengthen State and local program efforts.

1990–91

3. Support efforts to improve the training of health care professionals by encouraging outside persons and organizations, including State and local public health officials, to provide information on curriculum and program content and special subject selection (*Bureau of Health Professions*).

1990–91 **1992 and beyond**

• Encourage more public health awareness in the basic and continuing education of health professionals to increase cooperation between the public and private sectors of our health care system and to stimulate recruitment into public health occupations. Stress the link with public health education programs in written materials, such as program grant guidelines and funding preferences for appropriate grant programs.

4. Continue developing, under contract, an epidemiologic data base to identify community health needs. The data are drawn entirely from national sources. In FY 91, work through the State Primary Care Associations and cooperative agreements to refine the national data from State and local sources (*Bureau of Health Care Delivery and Assistance*).

1990–91 **1992 and beyond**

Food and Drug Administration (FDA)

1. Develop new methods, conduct collaborative studies, perform method validations, and initiate research in the area of biotechnology.
1990–91

2. Assess the feasibility of developing a model sentinel system problem reporting program for medical device post-marketing surveillance within one or more medical schools or university hospitals. The sentinel system could allow FDA to test the effectiveness of hospital reporting and to educate health care professionals concerning the need for problem reporting. (See assessment strategy 1, FDA item 4.)
1990–91

3. Increase efforts to encourage the development of more reliable tests which can offer early detection of HIV infection and thereby better protect the blood supply.
1992 and beyond

4. Explore the feasibility of joint research programs with industry and academia to increase understanding of biotechnology's impact on applied food science, as it relates to the safety of the food supply.
1992 and beyond

5. Promote increased sharing of pesticide residue data information between FDA, the food industry, States and others. This sharing will be part of a consensus building process designed to increase involvement of all parties interested in, and affected by, the pesticide issue.
1992 and beyond

6. Based on the successful experience with pilot State contracts, develop a full scale initiative to curb the illegal sale, distribution, and use of animal drugs at the State level. The program is aimed at surveying drug sales, and distribution and use patterns at the State level, following up with effective regulatory initiatives under State authorities. (See assurance strategy 1, FDA item 41.)
1992 and beyond

Centers for Disease Control (CDC)

1. Develop State and local expertise, through training and personnel development, and provide assistance for the conduct of epidemiologic investigations and studies designed to assess the health status of subject populations.
1990–91 **1992 and beyond**

2. Provide support, resources, technical assistance, and skills needed for States to use the health information data to assess progress toward goals for high priority health conditions.

• Encourage States to designate a lead person to coordinate surveillance activities of each State agency.
1992 and beyond

• Expand the Behavioral Risk Factor Surveillance System to all States for monitoring health-related behaviors and establish the capacity of States to conduct health surveys. Include the training of personnel for conducting surveys.
1990–91 **1992 and beyond**

• Provide technical assistance to State health departments in analyzing morbidity and mortality data related to tobacco use and in monitoring the economic burden of tobacco use.
1990–91

• Enhance the ability of State and local public health agencies to use alternative resource strategies for accomplishing routine public health laboratory functions.
1990–91 **1992 and beyond**

• Convene a national meeting involving State and local health departments to focus on the surveillance of work-related diseases and injuries.
1990–91

• Provide all State health departments with information on the processes and procedures for requesting Health Hazard Evaluations.
1990–91

• Inform State health departments of the training programs of the National Institute for Occupational Safety and Health, through its Educational Resource Centers, Project MINERVA (business schools), Project SHAPE (engineering schools), and Project EPOCH (medical schools).
1990–91

• Include occupational disease and injury case studies as part of epidemiologic training offered State health department staff members.

1992 and beyond

• Negotiate with State health departments to identify the person responsible for policy for occupational safety and health.

1992 and beyond

3. Prepare and propose a budget initiative to increase the capacity of the State and local public health systems to carry out the assessment function. Examples follow.

• Activities required to develop a Uniform National Data Set for measuring health status. A minimum standardized data set is proposed for participating agencies to collect data in a uniform manner.

1992 and beyond

• Systems to help State and local agencies track the Healthy People 2000 Objectives.

1992 and beyond

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

1. Support and encourage the use of NIDA data resources by widely disseminating information on and improving existing data collection systems; provide technical support and assistance to enhance data collection capabilities at the State level through adoption of national data standards (*National Institute on Drug Abuse*).

1990–91 **1992 and beyond**

2. Provide prevalence estimates for children's mental disorders, risk factors, need for services, and use of services, to State and local health agencies for public health planning and prevention. Estimates are to be based on results of the Child Cooperative Agreement Program for Multi-Site Surveys of Mental Disorders in Child and Adolescent Populations, of the National Institute of Mental Health.

1992 and beyond

3. Complete a feasibility contract with the National Association of State Mental Health Program Directors Research Institute, Inc., for development of a longitudinal data base for patient care episodes in State mental hospital inpatient programs (*National Institute of Mental Health*).

1990–91

4. Complete the second phase of a contract with the NASMHPD Research Institute, Inc. to assess the feasibility of a State mental health agency profile system (*National Institute of Mental Health*).

1992 and beyond

5. Determine the need for a new round of Mental Health Statistics Improvement Program implementation grants to incorporate the revised data standards in State mental health agency and local decision support system (*National Institute of Mental Health*).

1992 and beyond

6. Establish a national consultant exchange to provide information and technical assistance to alcohol, drug abuse, and mental health treatment programs (*Office for Treatment Improvement*).

1990–91 **1992 and beyond**

7. Relay information on drug abuse from the National Institute on Drug Abuse to appropriate sources for general public and professional awareness and action purposes (*Office for Substance Abuse Prevention*).
1990–91 **1992 and beyond**

8. Maintain Regional Alcohol and Drug Abuse Resource centers to promote better health communications (*Office for Substance Abuse Prevention*).
1990–91 **1992 and beyond**

9. Conduct a national conference to facilitate information sharing on effective strategies for working with high risk youth and pregnant and post partum women and their infants (*Office for Substance Abuse Prevention*).
1990–91 **1992 and beyond**

10. Conduct two conferences for new grant recipients to facilitate information sharing (*Office of Substance Abuse Prevention*).
1990–91

Agency for Toxic Substances and Disease Registry (ATSDR)

Continue developing and making accessible information and information systems concerned with the health effects of toxic substances. Provide appropriate user instruction on the interpretation and use of the system elements. Examples follow.
1990–91

- Provide training on the access and public health application of the National Library of Medicine toxicological data bases for State and local health officials.

- Enter cooperative agreements for training State health officials to conduct health assessments, training State and local health officials to respond to chemical emergencies, and training medical practitioners to examine and assess patients with toxic exposures.

Agency for Health Care Policy and Research (AHCPR)

Continue to make available, through the User Liaison Program, health services research findings relevant to State and local issues.
1990–91 **1992 and beyond**